Patient Information

Name:_____ Date of Birth:_____
Age: _____ Gender: M / F Height:_____ Weight:_____
Address:_____ City: _____ Zip: _____
Home phone: _____ Cell Phone: _____ Email:_____
Spouse Name: _____ Spouse phone:_____
Patient Employer: _____ Work phone: _____
Patient Occupation: _____

Person to contact in case of emergency
First and Last Name: _____ Phone:_____

Referring Physician:_____ Primary Physician: _____
Date of Injury: _____ Date of Surgery:_____

How did you hear about us? ___ Website ____MD Referral ____ Friend/Family ____ Advertisement
Other: _____

Method of payment:___ Private insurance ___Medicare ___ Work Comp ____ Self Pay
If you have Medicare, Do you have a secondary insurance policy? Yes / No

Please provide us with a copy of your insurance card(s)

If patient is a minor please provide us with the following:
Parent/Guardian Name: _____ Date of Birth: _____
Parent/guardian Employer: _____ Work phone: _____

Was this a motor vehicle accident? Yes / No If yes, please complete the following:
Name of motor vehicle insurance: _____ Phone: _____
Adjuster's Name: _____ Claim #: _____
Name of Insured: _____ Have an attorney? Yes / No
If yes, Name and phone: _____

Signature: _____ Date: _____

Medical History

Name:_____ Date of next Dr Appt: _____

Describe the history of your current accident, injury, illness or condition:

Onset date: _____ Description: _____

_____

_____

Special concerns, questions or expectations: _____

_____

Have you fallen in the past year? Yes / No If yes, how many times? _____

If yes, did you sustain an injury? _____

_____

Have you had any physical therapy during the current calendar year? Yes / No

If yes, for what? _____ When? _____ Where?_____

List all medications you are currently taking or provide us a list: _____

_____

_____

List all recent diagnostic studies (CAT Scan, MRI, X-ray, etc) When and Where: _____

_____

Do you have any metal anywhere in your body, other than teeth? Yes / No

If yes, please describe: _____

List all surgeries and dates: _____

_____

Please mark Yes (Y) or No (N) for each of the following:

Allergies	Y N	Dizzy Spells	Y N	MRSA	Y N
Anemia	Y N	Emphysema/Bronchitis	Y N	Multiple Sclerosis	Y N
Anxiety	Y N	Fibromyalgia	Y N	Muscular Disease	Y N
Arthritis	Y N	Fractures	Y N	Osteoporosis	Y N
Asthma	Y N	Gallbladder Problems	Y N	Parkinson's	Y N
Autoimmune Disorder	Y N	Headaches	Y N	Rheumatoid Arthritis	Y N
Cancer	Y N	Hearing Impairment	Y N	Seizures	Y N
Cardiac Conditions	Y N	Hepatitis	Y N	Smoking	Y N
Cardiac Pacemaker	Y N	High Cholesterol	Y N	Speech Problems	Y N
Chemical Dependency	Y N	High/Low Blood Pressure	Y N	Strokes	Y N
Circulation Problems	Y N	HIV / AIDS	Y N	Thyroid Disease	Y N
Currently Pregnant	Y N	Incontinence	Y N	Tuberculosis	Y N
Depression	Y N	Kidney Problems	Y N	Vision Problems	Y N
Diabetes	Y N	Metal Implants	Y N		

Signature: _____ **Date** _____

Authorization to Treat & Financial Policy

**Please initial the following:

____ I hereby authorize Complete PT to provide treatment as prescribed by my physician and consent to evaluation and treatment procedures which may be deemed advisable by my physician for medical care provided by Complete PT. I understand a variety of treatment options and techniques may be used. I understand that no assurance can be given that the course of treatment will improve my condition.

____ I hereby authorize the release of medical records to Complete PT and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

____ I hereby assign all insurance benefits for services rendered to which I am entitled to be paid directly to Complete PT. I understand that if my insurance company/third party payer denies payment or makes partial payment, I am responsible for the balance due.

____ I understand that as a courtesy, Complete PT will verify my benefits specific to outpatient physical therapy but that I am legally responsible for payment of all services rendered by Complete PT. It is your responsibility to know your insurance benefits. We always ask that you also call your insurance and double check the information we are provided.

____ If my insurance is being billed, I will be responsible for paying any deductible amounts. I understand that co-payments are due at time of service. (This does not apply to worker's compensation patients.)

____ If your deductible has **NOT** been satisfied you are required to pay $130 for the evaluation, then $75 per visit at the time of service until your deductible is satisfied. You will then be billed the remaining amount, if there is any. If your out of pocket maximum has **NOT** been satisfied you are responsible to pay the approximate co-insurance amount per visit until the amount is satisfied. You will be billed the remaining amount, if there is any.

____ You will be billed monthly once your insurance has processed visits. You will **NOT** receive a bill until insurance has processed visits.

____ **No Call No Show** and frequent and/or last minute cancellations within 24 hours could result in a $100 fee. Your first offense will be waived, then moving forward you will be charged a $100 fee. We understand situations happen, we just ask you to respect us and openly communicate.

Rici Lowe with Elite Medical Billing is our billing specialist and she is based in Idaho. Therefore, the number she calls you from will have an Idaho area code. If any problems arise with any claims her company may contact you.

If you ever have any questions or concerns PLEASE request to speak with Gary or Liz. We appreciate you trusting us with your physical therapy services and we want to ensure you are receiving the best care possible in every aspect of your care.

Acknowledgement of Receipt

1. I have received a copy of this office's Notice of Privacy Practices Y/N initial____
2. I agree that PT/PTA students may participate in my physical therapy care. Y/N initial____

SIGNATURE OF PATIENT/GUARDIAN:_____ DATE:_____

PRINTED NAME:_____